STATE OF WISCONSIN
s. 149.12, Wis. Stats.

WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP)
APPLICATION FOR COVERAGE

SECTION 1. INSTRUCTIONS

To be considered for Wisconsin Health Insurance Risk Sharing Plan (HIRSP) coverage, applicants are required to:

1. Answer *all* questions completely to permit HIRSP to process the application. In order to process the application, HIRSP needs the applicant's Social Security Number and certain other personally identifiable information. Providing this information is voluntary. However, since HIRSP uses this information to determine eligibility, we cannot process the application without it. The personally identifiable information and Social Security Number will be kept confidential and used only in our administration of the HIRSP program, as authorized by Chapter 149, Wisconsin Statutes and federal law.
2. Submit separate applications and separate premium payments for each applicant.
3. Submit supporting documentation required to process the application.
4. To receive additional information regarding the HIRSP Plan call 1-800-828-4777

SECTION 2. APPLICANT INFORMATION

If you are a parent, legal guardian, or other legally responsible adult for the applicant, and are completing this application form for the applicant, provide your name _____

2A.	Last Name / First / Middle		2B. Gender ☐ M ☐ F	2C. Telephone Number ( ) —	
2D.	Street Address	City	State	ZIP Code	2E. Date of Birth (MM/DD/YYYY)
2F.	Social Security Number (Optional-see section 1, #1)		2G. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated		

SECTION 3. RESIDENT ELIGIBILITY

To be eligible for HIRSP, you must be a resident of the State of Wisconsin. You are a resident if you live in this state for at least three months (unless you lost insurance through employer-sponsored group, government, or church plan) and Wisconsin is your legal residence. You must show Wisconsin is your legal residence by at least one of the following: a Wisconsin driver's license, registration to vote in Wisconsin, and/or a Wisconsin income tax return. A child is a resident if the child lives in this state and at least one of the child's parents or legal guardian meets the above residency requirements. A person with a disability that prevents him or her from obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return is a resident if the person's permanent physical address is in this state.

3A. Have you been a Wisconsin resident for at least three months as of the HIRSP effective date? (refer to section 15) ..... ☐ Yes ☐ No

3B. Have you been a Wisconsin resident for less than three months and lost your insurance through employer-sponsored group, government, or church plan?. ..... ☐ Yes ☐ No

SECTION 4. OTHER FAMILY MEMBERS ENROLLED IN HIRSP

4A. HIRSP offers a family out-of-pocket cost maximum if a family has more than one member in the same HIRSP plan. Refer to the table on page 9 of this application for more information. Is another person in your family applying for or insured under HIRSP? ☐ Yes ☐ No

If you answered "Yes" to 4A above, complete 4B, 4C, 4D, and 4E below. For each family member applying for or insured under HIRSP attach extra pages to this application if you need more room. Remember that a separate application, supporting documentation, and premium payment must be submitted for each person applying for HIRSP coverage.

4B. Name of family member applying or enrolled in HIRSP

4C. Relationship to You	4D. Check One ☐ Already on HIRSP ☐ Applying for HIRSP

4E. Policy Number _____

SECTION 5. EMPLOYER HEALTH COVERAGE

To be eligible for HIRSP, you cannot be eligible for insurance through employer-sponsored group, government, or church plan. Fill in the information requested in 5A through 5E below for the applicant (or parent, legal guardian or other legally responsible adult for the applicant if applicant is a dependent child), and, if applicable, spouse (or other parent if the applicant is a dependent child). **HIRSP will contact any employers listed on this application for the purpose of verifying employment and insurance information.**

	APPLICANT (or parent if applicant is a dependent child)	**SPOUSE** (or other parent if applicant is a dependent child)
5A. Employment Status	☐ Employed Full-Time ☐ Employed Part-Time _____ Hours/Week ☐ Self-Employed ☐ Unemployed	☐ Employed Full-Time ☐ Employed Part-Time _____ Hours/Week ☐ Self-Employed ☐ Unemployed
5B. Does your employer offer health coverage? If yes, why are you (your dependent) not covered on your employer-sponsored health coverage?	☐ Yes ☐ No	☐ Yes ☐ No
5C. Employer Name		
5D. Employer Address		
5E. Employer Phone Number		

SECTION 6. REASON FOR APPLICATION

There are two ways to be eligible for HIRSP. You may be eligible because you lost your employer-sponsored group, government, or church plan, or you may be eligible due to health reasons.

6A. Why are you applying for HIRSP?

You lost insurance through employer-sponsored group, government, or church plan within the last 63 days ☐ Yes ☐ No
If yes, complete section 8A - 8E

You are applying due to health reasons ☐ Yes ☐ No
If yes, complete section 9A - 9G

SECTION 7. WISCONSIN MEDICAID ELIGIBILITY

To be eligible for HIRSP, you cannot be eligible for Wisconsin Medicaid.

7A. Have you been covered by health benefits under Wisconsin Medicaid (also referred to as Medical Assistance or Title 19 or Badger Care)? ☐ Yes ☐ No

7B. If this coverage is terminating, provide your termination date (MM/DD/YYYY) |__|__|__|__|__|__|__|__|

7C. Provide your 10-digit Medicaid number. |__|__|__|__|__|__|__|__|__|__|

If you are no longer eligible for Wisconsin Medicaid and apply for coverage under HIRSP within 45 days after the termination and are subsequently found to be eligible for HIRSP, your policy effective date will be the date your Medicaid coverage was terminated.

SECTION 8. LOST INSURANCE THROUGH EMPLOYER-SPONSORED GROUP, GOVERNMENT, OR CHURCH PLAN

If you are applying for HIRSP because you lost insurance through employer-sponsored group, government, or church plan, you may not be subject to a six-month waiting period for coverage of pre-existing conditions. (A pre-existing condition is a condition, whether physical or mental, regardless of the cause, which was diagnosed or for which medical advice, care, or treatment was recommended or received during the six months immediately preceding the policy effective date.)

8A. Were you offered continuation coverage under your employer-sponsored group, government, or church plan, including state continuation coverage or Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage? ☐ Yes ☐ No

8B. If offered continuation coverage under your employer-sponsored group, government, or church plan, including state continuation coverage or COBRA, did you exhaust the coverage? ☐ Yes ☐ No

8C. You certify that this coverage was not canceled due to nonpayment, fraud, or misrepresentation of the facts on your application? ☐ Yes ☐ No

8D. Including this employer-sponsored group, government, or church plan, have you had continuous insurance coverage for at least 18 months with no gap in coverage greater than 63 days? ☐ Yes ☐ No

8E. Are you applying to HIRSP within 63 days of losing insurance through employer-sponsored group, government, or church plan? ☐ Yes ☐ No

If you answered "Yes" to questions 8A through 8E, *you must attach to your application a copy of your certificate of creditable coverage (or other supporting documentation) from past insurers or employers to document your 18 months of continuous coverage. A certificate of creditable coverage is a written certification of prior health coverage issued by the previous health plan. The certificate must identify the covered person and period of coverage.*

If you answered "No" to any of the questions 8A through 8E above, you may be eligible for HIRSP due to health reasons. Complete the next section on Eligibility Due to Health Reasons.

SECTION 9. ELIGIBILITY DUE TO HEALTH REASONS

9A. Are you eligible for Medicare because of a disability? ☐ Yes ☐ No

9B. Have you tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

9C. In the past nine months, did you receive a notice of rejection due to health reasons from two insurers? ☐ Yes ☐ No

9D. In the past nine months, did you receive a notice of cancellation due to health reasons from an insurer? ☐ Yes ☐ No

9E. In the past nine months, did you receive a notice of significant reduction of coverage due to health reasons from an insurer? ☐ Yes ☐ No

9F. In the past nine months, did you receive a notice of an increase in your premium of 50% or more due to health reasons? ☐ Yes ☐ No

9G. In the past nine months, did you receive two or more offers for insurance with premiums at least 50% higher than what you would be charged for a standard individual policy with substantially the same coverage and deductibles as HIRSP due to health reasons? ☐ Yes ☐ No

If you answered "Yes" to at least one of the questions 9A through 9G, *you must attach to your application a copy of the notice(s) from your insurance company(ies) of rejection, reduction or cancellation, premium increases, Medicare card or documentation that you are HIV positive. If you qualify for HIRSP based on the above requirements, you will be subject to a six-month waiting period for coverage of pre-existing conditions. You will need to enclose copies of the applicable notices.*

SECTION 10. PREVIOUS ENROLLMENT IN HIRSP

If you were previously covered under HIRSP and voluntarily terminated your HIRSP coverage, you are not eligible for coverage until 12 months have elapsed. This 12-month requirement does not apply if you are eligible for HIRSP because you lost insurance through employer-sponsored group, government, or church plan and answered "Yes" to all questions in Section 8 of this application or terminated HIRSP coverage because you were eligible to receive Medicaid benefits.

10A. Have you ever been enrolled before in Wisconsin HIRSP? ☐ Yes ☐ No

10B. **If you answered "Yes" to 10A above,** provide the following information:

Policyholder Identification Number		Cancellation Month / Year	
Name at time of HIRSP Coverage			

SECTION 11. OTHER MEDICAL COVERAGE

11A. Are you currently covered by any other medical plan? ☐ Yes ☐ No

If you answered "Yes" to 11A above, complete 11B and 11C. If you answered "No," complete 11D.

11B. Your other medical plan is a(n)

☐ Continuation coverage or COBRA

☐ Group health coverage offered through an employer

☐ Individual medical plan

☐ Other _____

11C. Provide the following information for your other medical plan.

Name of Insurance Company		Telephone Number	
Policy Identification Number		Termination Date (MM/DD/YYYY)	

11D. **If you answered "No" to 11A above,** provide a brief explanation for not having medical coverage

SECTION 12. FOR HIRSP APPLICANTS WHO HAVE MEDICARE

12A. Are you eligible for Medicare?. ☐ Yes ☐ No
If you answered "Yes" to 12A above, continue to question 12B.
If you answered "No" to 12A above, continue to Section 13. *Important: You may only select Plan 1, Option A or Plan 1, Option B in Section 13.*

12B. Indicate the Medicare plan(s) in which you are enrolled.....
☐ Part A
☐ Part B
☐ Part D
If you are enrolled in Medicare Part A, Part B, and Part D continue to questions 12C, 12D and 12E. *Important: You may only select Plan 2 in Section 13.*
If you are not enrolled in Medicare Part A, Part B, and Part D, you may only select Plan 1 in Section 13 and must be applying for HIRSP due to health reasons. You must complete Section 9 and include a letter of rejection due to medical reasons.

12C. Attach a copy of your Medicare card with this application and in the following space enter your Medicare Part A and Part B identification number: .....

12D. Attach a copy of your current Medicare Part D Prescription Drug Plan card with this application and in the following space enter your current Medicare Part D Prescription Drug Plan identification number:.....

12E. In the following space enter the effective date of your current Medicare Part D Prescription Drug Plan (MM/DD/YYYY):.....

SECTION 13. CHOICE OF HIRSP PLANS

HIRSP offers two coverage plans, which are summarized in the HIRSP Plan Options Table on page 9 of this application. For more details refer to the HIRSP Outline of Coverage for an explanation of available plans and benefits. Your application cannot be processed if you do not choose a plan.

13A. This application is for the following HIRSP plan (choose one only):

☐ Plan 1, Option A
(Lower Deductible. Higher Premium)

☐ Plan 1, Option B
(Higher Deductible. Lower Premium)

☐ Plan 2

Plan 2 is **ONLY** available for applicants who are:

- Younger than age 65 and eligible for Medicare due to a disability **AND**
- Enrolled in Medicare Part A **AND**
- Enrolled in Medicare Part B **AND**
- Enrolled in Medicare Part D

SECTION 14. REDUCED PREMIUM QUALIFICATION

For Plan 1, Option A or Plan 2, if your annual household income is less than $25,000 a year, you may qualify for a reduced premium. Refer to the application for reduced premium in your information packet or call 1-800-828-4777 to have one mailed to you.

14A. My annual household income is $ _____

Complete application for reduced premium and submit with this application.

SECTION 15. HIRSP EFFECTIVE DATE

The earliest date your coverage may be effective is the date HIRSP receives your completed application *and* the full amount of your first premium payment. You may not request an effective date more than 60 days after the date you sign this application. To honor your requested effective date, HIRSP must receive your full premium payment with your application. Your 6 month waiting period for coverage of pre-existing conditions, if applicable, begins on your effective date.

15A. Do you request an effective date other than the date HIRSP receives your completed application and premium?..... ☐ Yes ☐ No

15B. **If you answered "Yes" to 15A above,** indicate your requested effective date (MM/DD/YYYY).....

SECTION 16. YOUR PREMIUM AND PAYMENT AUTHORIZATION

(Choose the method you will use to pay your premium)

Advance premium deposit submitted with application $ _____

(If automatic withdrawal or quarterly direct billing, include a check for the full amount of your monthly or quarterly premium.)

Select How You Want To Pay Your Premiums

16A. ☐ **Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly or quarterly (You will not receive a monthly billing statement with this option.)

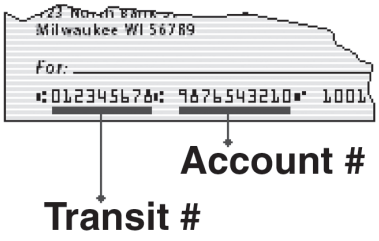
Choose automatic withdrawal frequency ☐ Monthly ☐ Quarterly

Account Holder Information

Name _____

Address _____

Financial Institution Information



Institution Name _____

Branch / Location _____

Address _____

Check One ☐ Checking Account ☐ Savings Account

Transit Number: _____ Account Number: _____

Indicate the day of month on which you wish to have your premium payment withdrawn from your account.

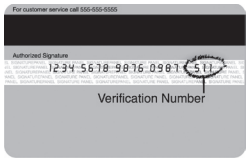
Day of month _____ (choose between the 1st and 31st of the month)

By signing below, you authorize HIRSP to instruct your financial institution to deduct your premium payments from the account designated above. You authorize your financial institution to debit the amount of your premium from your designated account. This authorization will remain in effect until you notify HIRSP in writing of its termination. Your notification must afford HIRSP and your financial institution reasonable opportunity to act on it.

Signature _____ Date Signed _____/_____/_____

OR

16B. ☐ **Credit / Debit Card** Select One ☐ Visa ☐ MasterCard ☐ Discover Card



Choose payment frequency: ☐ Monthly ☐ Quarterly

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ____/____

Credit / Debit Card Number Card Expiration Date

___ ___ ___

Credit / Debit Verification Number *(This number is located on the back of your credit card. It's the three-digit number found after your card number.)*

Name as it appears on card _____

Card Billing Address _____

Indicate the day of month on which you wish to have your premium payment charged to your account.

Day of month _____ (choose between the 7th and 31st of the month)

By signing below you authorize HIRSP or its authorized credit/debit card transaction agent(s) to bill the credit/debit card account indicated above for payment of premiums charged for the HIRSP policy for which you are applying. You understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions.

Signature _____ Date Signed _____/_____/_____

OR

16C. ☐ **Quarterly Direct Billing.** You will be sent a bill on a quarterly basis. (March, June, September, and December)

SECTION 17. AGENT INFORMATION

If an insurance agent provided you with this application form, helped you complete and submit the application, and your application is approved, HIRSP will reimburse the agent $35.00 for his or her time. Have the agent complete the following section.

Signature – Agent	Date Signed

Name – Agent (Print)

Wisconsin Insurance License Number

Tax Identification Number / Social Security Number

Name – Agency

Street Address

City, State, ZIP Code

Telephone Number

SECTION 18. CERTIFICATION AND SIGNATURE

You certify that you are not covered under an employer-sponsored group, government, or church plan and that the foregoing statements are true to the best of your knowledge and belief. You understand that no coverage will be effective until you pay the full amount of the premium for coverage and HIRSP approves this application. You understand that you are subject to disenrollment and possible prosecution under state and federal laws if this information is false. You will notify HIRSP in writing (PO Box 8961, Madison, WI 53708-8961) of any change of name, income, insurance, employment status, address, or telephone number. **You agree to allow HIRSP to contact any employers listed on this application for the purpose of verifying employment and insurance information.** You understand you are responsible for all medical costs of services not covered by HIRSP. You are hereby informed of your rights to appeal a denial of eligibility.

SIGNATURE — Applicant	Date Signed
SIGNATURE — Parent or legal guardian if applicant is under age 18 or legally incompetent.	Date Signed

Refer to the Checklist section on the next page to make sure your application is complete.

This conditional receipt is issued with the understanding that, while your application is going through processing, your payment will be cashed, however you will not be covered until your eligibility is determined and you are approved.

NOTE: If you have not received the HIRSP policy or your premium payment is not returned within 6 weeks from the date shown above, notify our HIRSP Customer Service Department at the address shown above or call 800-828-4777.

CHECKLIST

You must remember to provide the following information with your application.

Wisconsin Residency for at least three months (all applicants)

- ☐ Attach either a copy of your driver's license, documentation of voter registration, and/or Wisconsin income tax return.

Lost Coverage from Employer (if you've answered "yes" to all questions in Section 8).

- ☐ Attach copies of your certificate(s) of creditable coverage.

Medical Condition (if you've answered "yes" to at least one question in Section 9)
Attach one of the following documents to support your eligibility based on a medical condition.

- ☐ Documentation that you are HIV positive
- ☐ Notice of rejection of coverage from two or more insurers
- ☐ Notice of cancellation of coverage
- ☐ Notice of significant reduction in coverage
- ☐ Notice of increase in premium of 50%
- ☐ Two or more offers of insurance with premiums at least 50% higher than what you would be charged for a standard individual policy with substantially the same coverage and deductibles as HIRSP

Medicare (if you've completed Section 12)

- ☐ Copy of Medicare card
- ☐ Copy of Medicare Part D Prescription Drug Plan card

Other Required Information

- ☐ Include separate checks and applications for each applicant.
- ☐ If you have selected Automatic Withdrawal, include a check for the full amount of your monthly or quarterly premium. Subsequent premium payments will be automatically deducted from your account either monthly or quarterly depending on your selection.
- ☐ If you have selected Quarterly Direct Billing, include a check for the full amount of your quarterly premium. You will then be billed quarterly for your premium payments. You will submit these payments to HIRSP via check or money order.
- ☐ If your annual household income is less than $25,000 and you are applying for Plan 1, Option A or Plan 2, submit a HIRSP Application for Reduced Premium, Deductible, and Drug Coinsurance (HCF 12762) to determine if you qualify. Refer to the application for reduced premium in your information packet.
- ☐ Disclosure Statement-
  If you wish to authorize HIRSP to release your personal health information, including premium billing or claims billing, to another individual (spouse, other family member, or insurance agent) complete the Confidential Information Release Authorization Form at the time of your enrollment to avoid service delays or call 1-800-828-4777 to have a form mailed to you.

Mail your completed application, payment, and relevant documentation to: HIRSP at 1751 W Broadway, PO Box 8961, Madison, WI 53708-8961. If you have questions about this application call HIRSP customer service at 1-800-828-4777 or 1-608-221-4551.

Failure to comply with all application requirements may delay the effective date for your coverage under the HIRSP policy.

HIRSP PLAN OPTIONS TABLE

	Plan 1, Option A	Plan 1, Option B	Plan 2
Premiums	Refer to rate tables.	Refer to rate tables.	Refer to rate tables.
Premium reductions available if you qualify	Yes*	No	Yes*
Medical deductible (You pay)	**$1,000** per year	**$2,500** per year	**$500** per year
Medical deductible reductions available if you qualify	Yes**	No	No
Medical coinsurance (You pay)	**20%** of allowed amount **$1,000** total per year	**20%** of allowed amount **$1,000** total per year	No
Individual medical out-of-pocket maximum (your total expenditures for medical deductible and medical coinsurance, after which HIRSP will pay at 100%)	**$2,000** per year. This does not include drug coinsurance.	**$3,500** per year. This does not include drug coinsurance.	**$500** per year. This does not include drug coinsurance.
Family medical out-of-pocket maximum (All family members must be on the same plan.)	**$4,000** per year. This does not include drug coinsurance.	**$7,000** per year. This does not include drug coinsurance.	**$1,000** per year. This does not include drug coinsurance.
Drug coinsurance (You pay)	**20%** of the allowed amount up to a maximum of **$25** per prescription.	**20%** of the allowed amount up to a maximum of **$25** per prescription.	**20%** of the allowed amount up to a maximum of **$25** per prescription.
Drug coinsurance out-of-pocket maximum (Your total expenditures for drug coinsurance, after which HIRSP will pay at (100%)	**$750** per year. This is in addition to your medical coinsurance.	**$1,000** per year. This is in addition to your medical coinsurance.	**$125** per year. This is in addition to your medical coinsurance.
Drug coinsurance out-of-pocket maximum reductions available if you qualify	Yes**	No	No
Pre-existing condition waiting period	Refer to pages 8 & 9 of the HIRSP Outline of Coverage.	Refer to pages 8 & 9 of the HIRSP Outline of Coverage.	Refer to pages 8 & 9 of the HIRSP Outline of Coverage.
Maximum lifetime benefit	**$1,000,000**	**$1,000,000**	**$1,000,000**

* Available for policyholders with household incomes of less than $25,000.
** Available for policyholders with household incomes of less than $20,000.

WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP)

PO BOX 8961 • MADISON, WI 53708-8961

CUSTOMER SERVICE: (800) 828-4777 OR (608) 221-4551 FAX: (608) 226-8770

Grievance procedures for applicants and policyholders

If HIRSP denies an application or claim payment, the applicant or policyholder will receive directly from HIRSP a written notice of the denial, together with the specific reason for the denial.

An individual may request a review if he or she disagrees with HIRSP's decision to:

(1) Deny or terminate coverage.

(2) Deny or reduce payment of a claim.

(3) Deny an application for a subsidy of HIRSP deductible and/or premium.

HIRSP will not consider requests to review across-the-board premium rate increases.
These rates are set based on HIRSP's budgetary requirements and conditions as established by state law.

A policyholder may request a review of the actions listed above according to the following procedure.

Review by Plan Administrator
If the policyholder or applicant disagrees with HIRSP's decision, the individual may request a review by the plan administrator.The individual has **60 days** after the date of HIRSP's decision to request a further review by the plan administrator. To request the review, the policyholder must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the review.

Clearly indicate that the written request is for a review. This will help HIRSP process the request.

Mail the request for review to:

HIRSP
Appeals Department
PO Box 7062
Madison, WI 53707-7062

Upon receiving the request, the plan administrator will review the decision and either affirm, modify, or rescind it. The plan administrator will communicate this decision, and the reason for the decision, in a written response. The plan administrator has 10 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for more information.

Review by Grievance Committee
If the policyholder or applicant disagrees with the plan administrator's decision on the review, the individual may file a grievance. The individual has **30 days** after the date of the written results of the plan administrator's review to request a further review by the HIRSP Grievance Committee. To file a grievance, the individual must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the grievance.

Clearly indicate that the written request is a grievance. This will help the Grievance Committee process the request.

Mail grievances to:

HIRSP Grievance Committee
PO Box 7062
Madison, WI 53707-7062

Upon receiving the request, the Grievance Committee will review the decision and either affirm, modify, or rescind it. The Grievance Committee will communicate this decision, and the reason for the decision, in a written response within 45 days from the receipt of the request for review.